DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth under § 302(14) of the District of Columbia Health Occupations Revision Act of 1985 ("Act"), effective March 15, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02(14)), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of the adoption of the following amendments to Chapter 70 of Title 17 DCMR (Business, Occupations & Professions) (May 1990). The purpose of this rulemaking is to establish a Code of Ethics for the Practice of Social Work. Notice of Proposed Rulemaking was published in the D.C. Register on June 13, 2003 at 50 DCR 4755. No comments were received concerning these rules and no changes have been made since publication as a Notice of Proposed Rulemaking. These final rules will be effective upon publication of this notice in the D.C. Register.

Chapter 70 (Social Work) of Title 17 DCMR (Business, Occupations & Professions) (May 1990) is amended to read as follows:

A new section 7009 is added to read as follows:

7009 Standards of Conduct

7009.1 Any holder of a license under this Chapter or any person authorized to practice social work or to perform social work functions under this Chapter shall comply with the standards of ethical and professional conduct established by the National Association of Social Workers in its publication entitled "Code of Ethics," as it may be amended or republished from time to time.

-DEPARTMENT OF INSURANCE AND SECURITIES REGULATION

NOTICE OF FINAL RULEMAKING

The Commissioner of Insurance and Securities Regulation ("Commissioner"), pursuant to the authority set forth in sections 4, 5, 6, 9 and 11 of the Medicare Supplement Insurance Minimum Standards Act of 1992, effective July 22, 1992 (D.C. Law 9-170, D.C. Official Code §§ 31-3703, 31-3704, 31-3705, 31-3708 and 31-3710 (2001), and Mayor's Order 93-60, dated May 12, 1993, hereby gives notice of the adoption of an amendment to Chapter 22 (Medicare Supplement Insurance Minimum Standards) of Title 26 of the District of Columbia Municipal Regulation (DCMR) (Insurance).

The emergency action is necessary to ensure that the District's regulations regarding minimum standards for Medicare supplement insurance conform to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), enacted in § 1 (a) of the Fiscal Year 2001 Consolidated Appropriations Act, approved December 21, 2000 (Pub. L. 106-554; 114 Stat. 2763). Without this emergency action, the District of Columbia will not maintain certification of its regulatory programs, thereby resulting in an adverse effect on the health, safety and welfare of residents of the District of Columbia

A notice of emergency and proposed rules was published in the D.C. Register on February 7. 2003 (50 DCR 1248). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the D.C. Register.

26 DCMR, Chapter 22 (Medicare Supplement Insurance Minimum Standards) is amended to read as follows:

Chapter 22 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

2200 PURPOSE

2200.1 The purpose of this chapter is:

(a) To provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

(b) To facilitate public understanding and comparison of such policies;

(c) To eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

(d) To provide for full disclosure in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

2201 AUTHORITY

This chapter is issued pursuant to the authority vested in the Commissioner of Insurance and Securities Regulation under the Medicare Supplement Insurance Minimum Guidelines Act of 1992, effective July 22, 1992 (D.C. Law 9-170; D.C. Official Code § 31-3701 et seq.).

2202 APPLICABILITY AND SCOPE

2202.1 Except as otherwise specifically provided in sections 2206, 2209, 2211, 2217 and 2225, this chapter shall apply to:

(a) All Medicare supplement policies delivered or issued for delivery in the District of Columbia on or after May 1, 1999; and

(b) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in the District.

2202.2 This chapter shall not apply to:

(a) A policy or contract of one or more employers or labor organizations; or

(b) The trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

2203 RESERVED

2204 POLICY DEFINITIONS AND TERMS

2204.1 No policy or certificate may be advertised, solicited or issued for delivery in the District as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

2204.2 "Accident", "accidental injury", or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

2204.3 "Benefit period" or "Medicare benefit period" shall not be defined more

restrictively than as defined in the Medicare program.

2204.4 "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

2204.5 "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which are analogous to incurred losses of insurers. Expenses shall not include:

(a) Home office and overhead costs;

(b) Advertising costs;

(c) Commissions and other acquisition costs;

(d) Taxes;

(e) Capital costs;

(f) Administrative costs; and

(g) Claims processing costs.

2204.6 "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

2204.7 "Medicare" shall be defined in the policy and certificate and may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

2204.8 "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

2204.9 "Physician" shall not be defined more restrictively than as defined in the Medicare program.

2204.10 "Sickness" shall not be defined more restrictively than the following:

An illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force; and

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

2205 POLICY PROVISIONS

2205.1 Except for permitted preexisting condition clauses as described in subsections

2206.4 and 2207.4 of this chapter, no policy or certificate may be advertised, solicited or issued for delivery in the District as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

2205.2 No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

2205.3 No Medicare supplement policy or certificate in force in the District shall contain benefits which duplicate benefits provided by Medicare.

2206 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO MAY 1, 1999

2206.1 No policy or certificate may be advertised, solicited or issued for delivery in the District as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards.

2206.2 The standards contained in subsections 2206.3 through 2206.13 are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

2206.3 The following General Standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

2206.4 A Medicare supplement policy or certificate shall not:

(a) Exclude or limit benefits. for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and

(b) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2206.5 A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

2206.6 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, and premiums may be modified to correspond with such changes.

2206.7 A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

2206.8 Except as authorized by the Commissioner, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

2206.9 If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection 2206.3(h), the issuer shall offer certificate holders an individual Medicare supplement policy and shall offer certificate holders at least the following choices:

(a) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(b) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2207.14 of this chapter.

2206.10 If membership in a group is terminated, the issuer shall:

(a) Offer the certificate holder such conversion opportunities as are described subsection 2206.9; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

2206.11 If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

2206.12 Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

2206.13 The following Minimum Benefit Standards shall apply to Medicare supplement policies or certificates.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90^{th}) day in any Medicare benefit period;

(b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(c) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(d) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare

Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(e) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($100); and

(g) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

2207 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER MAY 1, 1999

2207.1 The standards contained in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District of Columbia on or after May 1, 1999.

2207.2 No policy or certificate may be advertised, solicited, delivered or issued for delivery in the District as a Medicare supplement policy or certificate unless it complies with these benefit standards.

2207.3 The following General Standards apply to Medicare supplement policies or certificates and are in addition to all other requirements of this chapter:

2207.4 A Medicare supplement policy or certificate shall not:

(a) Exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and

(b) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2207.5 A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

2207.6 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and premiums may be modified to correspond with such changes.

2207.7 No Medicare supplement policy or certificate shall provide for termination of

coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

2207.8 Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection 2207.8(e), the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder,

(1) Provides for continuation of the benefits contained in the group policy, or

(2) Provides for such benefits or otherwise meets the requirements of this subsection.

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(1) Offer the certificate holder the conversion opportunity described in subsection 2207.8(c); or

(2) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

2207.9 Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

2207.10 A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual

becomes entitled to such assistance.

2207.11 If such suspension occurs pursuant to subsection 2207.10 and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted, effective as of the date of termination of such entitlement, if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

2207.12 Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of such loss.

2207.13 Reinstitution of coverages:

(a) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(b) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(c) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

2207.14 The following standards for Basic ("Core") Benefits, common to all benefit plans, shall apply:

(a) Every issuer:

(1) Shall make available a policy or certificate including only the following Basic "Core" Package of Benefits, common to all benefits plans, to each prospective insured; and

(2) May make available to prospective insureds any of the other Medicare Supplement insurance Benefit Plans in addition to the Basic "Core" Package of Benefits, but not instead of the Basic "Core" package of Benefits.

(b) The Basic ("Core") Package of Benefits consists of the following:

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for

hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days; provided that the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

2207.15 The following Additional Benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section 2208 of this chapter:

(a) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;

(b) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(d) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(f) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare;

(g) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent

(50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare;

(h) Medically Necessary Emergency Care in a Foreign Country : Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of paragraph (h), "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset;

(i) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures;

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Digital rectal examination;

(B) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

(C) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(D) Serum cholesterol screening every five (5) years;

(E) Thyroid function test; and

(F) Diabetes screening.

(3) Tetanus and diphtheria booster (every ten (10) years);

(4) Any other tests or preventive measures determined appropriate by the attending physician.

(5) Reimbursement under this paragraph shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall

not include payment for any procedure covered by Medicare.

(j) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

(A) "Activities of daily living" includes, but is not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "Home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except that each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider shall be considered as one visit.

(2) Coverage Requirements and Limitations:

(A) At-home recovery services provided must be primarily services which assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) Coverage is limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician and the total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(iii) One thousand six hundred dollars ($1,600) per calendar year;

(iv) Seven (7) visits in any one week;

(v) Care furnished on a visiting basis in the insured's home;

(vi) Services provided by a care provider as defined in this section;

(vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(viii) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(D) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(k) New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards and the new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

2208 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

2208.1 An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the Basic "Core" Benefits, as defined in subsection 2207.14.

2208.2 No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in the District, except as may be permitted in subsection 2207.15(k).

2208.3 Benefit plans shall be uniform in structure, language, designation and format to the Standard Benefit Plans "A" through "J" listed in this subsection and conform to the definitions in section 2299.

2208.4 Each benefit shall be structured in accordance with the format provided in

subsections 2207.14 and 2207.15 and list the benefits in the order shown in subsection 2208.7.

2208.5 For purposes of section 2208, "structure, language, and format" means style, arrangement and overall content of a benefit.

2208.6 An issuer may use, in addition to the benefit plan designations required in subsection 2208.3, other designations to the extent permitted under District law.

2208.7 Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits common to all benefit plans, as defined in subsection 2207.14;

(b) Standardized Medicare supplement benefit plan "B" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.14; plus

(2) The Medicare Part A Deductible as defined in subsection 2207.15(a).

(c) Standardized Medicare supplement benefit plan "C" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a foreign Country as defined in subsection 2207.15(a), (b), (c) and (h);

(d) Standardized Medicare supplement benefit plan "D" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an foreign Country and the At-Home Recovery Benefit as defined in subsections 2207.15(a) and (b),(h), and (j);

(e) Standardized Medicare supplement benefit plan "E" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a foreign Country and Preventive Medical Care as defined in subsection 2207.5(a), (b), (h), and (i);

(f) Standardized Medicare supplement benefit plan "F" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a foreign Country as defined in subsections 2207.15(a), (b), (c), (e), and (h);

(g) Standardized Medicare supplement benefit plan "G" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, the Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (d), (h), and (j);

(h) Standardized Medicare supplement benefit plan "H" shall consist of only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in subsections 2207.15(a), (b), (f), and (h);

(i) Standardized Medicare supplement benefit plan "I" shall consist of only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (e), (f), (h), and (j).

(j) Standardized Medicare supplement benefit plan "J" shall consist of only the following:

(1) The Core Benefit as defined in subsection 2207.14; and

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (c), (e), (g), (h), (i), and (j);

(k) Standardized Medicare supplement benefit high deductible plan "F" shall include only 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in section 2207, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsections 2207.15(a), (b), (c), (e) and (h). The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses other than premiums for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be fifteen hundred dollars ($1500) for 1998 and 1999, and shall be based on the calendar year. It shall include the annual adjustments made thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(l) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in section 2207 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in sections 2207.15(a), (b), (c), (d), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible shall consist of out-of -pocket expenses other than premiums for services covered by the Medicare supplement "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars ($1500) for 1998 and 1999, and shall be based on the calendar year. It shall include the annual adjustments made thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

2209 GUARANTEED ISSUE FOR ELIGIBLE PERSONS

2209.1 An eligible person shall be any of the individuals described in subsection 2209.3 who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection 2209.3, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

2209.2 With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection 2209.4 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

2209.3 An eligible person is an individual described in any of the following:

(a) The individual is enrolled under an employee welfare benefit plan providing health benefits which supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(b) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

(1) The organization's or plan's certification has been terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(2) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g) (3) (B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(3) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(A) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(4) The individual meets such other exceptional conditions as the Secretary may provide.

(c) The individual is:

(1) Enrolled with one of the following:

(A) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);

(B) A similar organization operating under demonstration project authority, effective for periods beginning prior to

April l, 1999;

(C) An organization under an agreement under section 1833 (a) (1) (A) of the Social Security Act (Health care prepayment plan); or

(D) An organization under a Medicare Select policy; and

(2) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection 2209.3(b) of this chapter.

(d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization, or of other involuntary termination of coverage of enrollment under the policy;

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(e) The individual:

(1) Was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls for the first time with any Medicare+ Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833 (a) (1) (A) of the Social Security Act (health care prepayment plan), or a Medicare Select policy; and

(2) The subsequent enrollment under subparagraph (1) of this paragraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

(f) The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

2209.4 The Medicare supplement policy to which an eligible person is entitled under:

(a) Subsections 2209.3(a),(b),(c)and(d) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F offered by any issuer;

(b) Subsections 2209.3(e) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (a) of this subsection;

(c) Subsection 2209.3(f) shall include any Medicare supplement policy offered by any issuer.

2209.5 Notification shall be provided as follows:

(a) At the time of an event described in subsection 2209.3 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection 2209.2. Such notice shall be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in subsection 2209.3 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection 2209.2. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

2209.6 Guaranteed issue time periods shall be as follows:

(a) In the case of an individual described in subsection 2209.3(b), the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends sixty-three (63) days after the date of the applicable notice;

(b) In the case of an individual described in subsection 2209.3(b), 2209.3(c) 2209.3(e) or 2209.3(f) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(c) In the case of an individual described in subsection 2209.3(d), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuers's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated;

(d) In the case of an individual described in subsections 2209.3(b), 2209.3(d)(2), 2209.3(d)(3), 2209.3(e), 2209.3(f) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-

three (63) days after the effective date; and

(e) In the case of an individual described in subsection 2209.3 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

2209.7 Extended Medigap access for interrupted trial periods shall be as follows:

(a) In the case of an individual described in subsection 2209.3(e) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subsection 2209(e)(1) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section 2209.3(e);

(b) In the case of an individual described in subsection 2209.3(f) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in subsection 2209.3(f) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program , the subsequent enrollment shall be deemed to be an initial enrollment described in subsection 2209.3(f); and

(c) For purposes of subsections 2209.3(e) and 2209.3(f), no enrollment of an individual with an organization or provider described in subsection 2209.3(e)(1), or with a plan or in a program described in subsection 2209.3(f), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

2210 OPEN ENROLLMENT

2210.1 No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in the District, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B.

2210.2 Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under subsection 2210.1 without regard to age.

2210.3 If an applicant qualifies under subsection 2210.1 and submits an application during the time period referenced in subsection 2210.1 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2210.4 If an applicant qualifies under subsection 2210.1 and submits an application during the time period referenced in subsection 2210.1 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the

aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this section shall be that specified by the Secretary.

2210.5 Except as provided in subsections 2210.3 and 2210.4, and section 2227, subsection 2210.1 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

2211 STANDARDS FOR CLAIMS PAYMENT

2211.1 An issuer shall comply with section 1882(c) (3) of the Social Security Act (as enacted by section 4081(b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203) by:

(a) Accepting a notice from a Medicare carrier on duly assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

2211.2 Compliance with the requirements set forth in subsection 2211.1 shall be certified on the Medicare supplement insurance experience reporting form.

2212 LOSS RATIO STANDARDS

2212.1 A Medicare supplement insurance policy form or certificate form shall not be delivered or issued for a delivery in the District unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) At least seventy-five percent (75%) of the aggregate amount of premiums

earned in the case of group policies; or

(b) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

2212.2 The loss ratios set forth in subsection 2212.1 shall be calculated on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices.

2212.3 All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section 2212 when combined with actual experience to date.

2212.4 Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

2212.5 For purposes of applying subsections 2212.1, 2212.2 and section 2216 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

2212.6 For policies issued prior to October 1, 1992 expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from subsection 2212.1(a) and (b) when combined with actual experience beginning with May 1, 1999 to date; and

(c) The appropriate loss ratio requirement from subsection 2212.1(a) and (b) over the entire future period for which the rates are computed to provide coverage.

2213 REFUND OR CREDIT OF PREMIUM

2213.1 An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a Standard Medicare Supplement Benefit Plan, described in section 2208.

2213.2 If on the basis of the experience as reported the benchmark loss ratio since inception (ratio 1) exceeds the adjusted experience loss ratio since inception (ratio 3), then a refund or credit calculation is required.

(a) The refund calculation shall be done on a District-wide basis for each type in a standard Medicare supplement benefit plan.

(b) For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(c) For purposes of this section, with regard to policies or certificates issued prior to July 22, 1992 the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined, and all group policies combined for experience after May 1, 1999. The first such report shall be due by May 31, 2001.

2213.4 A refund or credit shall be made only when:

(a) The benchmark loss ratio exceeds the adjusted experience loss ratio; and

(b) The amount to be refunded or credited exceeds a de minimis level.

2213.5 The refund or credit described in subsection 2213.4 shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event shall it be less than the average rate of interest of thirteen (13) week Treasury notes.

2213.6 A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

2214 ANNUAL FILING OF PREMIUM RATES

2214.1 An issuer of Medicare supplement policies and certificates issued in the District before or after the effective date of this chapter shall file annually its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, for approval by the Commissioner of the Department of Insurance and Securities Regulation in accordance with the filing requirements and procedures prescribed by the Commissioner.

2214.2 The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed and such demonstration shall exclude active life reserves.

2214.3 An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

2214.4 As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in the District shall file with the Commissioner:

(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates; and

(b) Supporting documents as necessary to justify the adjustment.

2214.5 An issuer shall make premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies

and certificates.

2214.6 No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

2214.7 If an issuer fails to make acceptable premium adjustments, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by section 2212.

2214.8 Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare and the riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

2215 PUBLIC HEARINGS.

2215.1 The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 22, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard.

2215.2 The determination of compliance shall be made without consideration of any refund or credit for such reporting period.

2215.3 Public notice of such hearing shall be furnished in a manner deemed appropriate by the Commissioner.

2216 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES

2216.1 An issuer shall not:

(a) Deliver or issue for delivery a policy or certificate to a resident of the District unless the policy form or certificate form has been filed with and approved by the Commissioner; and

(b) Use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner.

2216.2 Except as provided in subsection 2216.3, an issuer shall not file for approval more than one form of a policy or certificate of each type for each Standard Medicare Supplement Benefit Plan described in section 2208.

2216.3 An issuer may offer, with the approval of the Commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same Standard Medicare Supplement Benefit Plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage; and

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

2216.4 For the purposes of this section 2216, a type means an individual policy or a group policy.

2216.5 Except as provided in subsections 2216.7 and 2216.8, an issuer shall continue to make available for purchase any policy form or certificate form issued after May 1, 1999 that has been approved by the Commissioner.

2216.6 A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

2216.7 An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate.

2216.8 After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in the District.

2216.9 An issuer that discontinues the availability of a policy form or certificate form pursuant to subsections 2216.7 and 2216.8 shall not file for approval a new policy form or certificate form of the same type for the same Standard Medicare Supplement Benefit Plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance.

2216.10.1 The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

2216.11 The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of subsections 2216.5, 2216.6, 2216.7, 2216.8, 2216.9, and 2216.10.

2216.12 A change in the rating structure or methodology shall be considered a discontinuance under subsections 2216.5, 2216.6, 2216.7, 2216.8, and 2216.9, and 2216.10, unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change; and

(c) The Commissioner may approve a change to the differential that is in the public interest.

2216.13 Except as provided in subsection 2216.11;

(a) The experience of all policy forms or certificate forms of the same type in a Standard Medicare Supplement Benefit Plan shall be combined for purposes of the refund or credit calculation prescribed in section 2213;

(b) Forms-assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation;

(c) An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after May 1, 1999 based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

2217 PERMITTED COMPENSATION ARRANGEMENTS

2217.1 An issuer or other entity may provide a commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

2217.2 The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

2217.3 No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation, greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

2217.4 For purposes of section 2217, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

2218 REQUIRED DISCLOSURE PROVISIONS - GENERAL RULES

2218.1 Medicare supplement policies and certificates shall include a renewal or continuation provision and the language or specifications of such provision shall be consistent with the type of contract issued.

2218.2 The renewal or continuation provision shall:

(a) Be appropriately captioned;

(b) Appear on the first page of the policy; and

(c) Include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2218.3 Except for riders or endorsements by which the issuer effectuates a request made

in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured.

2218.4 After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the Minimum Standards for Medicare Supplement Policies, or if the increased benefits or coverage is required by law.

2218.5 Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

2218.6 Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

2218.7 If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

2218.8 Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

2218.9 Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person or persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services, and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter.

(a) Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer;

(b) Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered; and

(c) For the purpose of this section "form" means the language, format, type, size, type proportional spacing, bold character, and line spacing.

2219 REQUIRED DISCLOSURE PROVISIONS – NOTICE REQUIREMENT

2219.1 As soon as practicable, but no later than thirty (30) days prior to the annual

effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner.

2219.2 Notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2219.3 The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

2219.4 Such notices shall not contain or be accompanied by any solicitation.

2219.5 Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants A Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services, and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter.

(a) Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer.

(b) Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

2220 **REQUIRED DISCLOSURE PROVISIONS - OUTLINE OF COVERAGE REQUIREMENTS FOR MEDICARE SUPPLEMENT POLICIES.**

2220.1 Issuers shall:

(a) Provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant; and

(b) Except for direct response policies, obtain an acknowledgment of receipt of such outline from the applicant.

2220.2 If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall:

(a) Accompany such policy or certificate when it is delivered; and

(b) Contain the following statement, in no less than twelve (12) point type,

immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

2220.3 The outline of coverage provided to applicants pursuant to section 2220 consists of four parts:

(a) A cover page;

(b) Premium information;

(c) Disclosure pages; and

(d) Charts displaying the features of each benefit plan offered by the issuer.

2220.4 The outline of coverage shall be in the language and format prescribed in subsection 2220.9, in no less than twelve (12) point type.

2220.5 All plans A through J shall be shown on the cover page, and the plan(s) offered by the issuer shall be prominently identified.

2220.6 Premium information for plans offered shall be:

(a) Shown on the cover page or immediately following the cover page; and

(b) Prominently displayed.

2220.7 The premium and mode shall be stated for all plans that are offered to the prospective applicant.

2220.8 All possible premiums for the prospective applicant shall be illustrated.

2220.9 The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____[insert letters of plans being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs	Basic Drugs	Extended	

5910

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "*The Medicare & You Handbook*" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768]	$0	$[768](Part A deductible)
61st thru 90th day	All but $[192] a day	$[192] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[384] a day	$[384] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	$0	Up to $[96] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768]	$[768](Part A deductible)	$0
61st thru 90th day	All but $[192] a day	$[192] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[384] a day	$[384] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	$0	Up to $[96] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768]	$[768](Part A deductible)	$0
61st thru 90th day	All but $[192] a day	$[192] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[384] a day	$[384] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	Up to $[96] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[776]	$[776] (Part A deductible)	$0
61st thru 90th day	All but $[194] a day	$[194] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[388] a day	$[388] a day $0	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	Up to $[96] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768]	$[768] (Part A deductible)	$0
61st thru 90th day	All but $[192] a day	$[192] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[384] a day	$[384] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	Up to $[96] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
*PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1530] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[776]	$[776] (Part A deductible)	$0
61st thru 90th day	All but $[194] a day	$[194] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $[388] a day	$[388] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	Up to $[96] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(continued)

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1530] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved amounts*	$0	$100 (Part B deductible	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved amounts*	$0	$100 (Part B deductible	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $100 of Medicare approved Amounts*	$0	$100 (Part B deductible	$0
Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum

+-PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768]	$[768] (Part A deductible)	$0
61st thru 90th day	All but $[192] a day	$[192] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[384] a day	$[384] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	Up to $[96] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[776]	$[776] (Part A deductible)	$0
61st thru 90th day	All but $[194] a day	$[194] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[388] a day	$[388] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[96] a day	Up to $[96] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	0%	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs